13

13 Dentist

Certain dental health care services are available for eligible children under age 21 through Medicaid as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Dental services are any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment, which may affect the oral or general health of the individual.

The policy provisions for dental providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 15.

13.1 Enrollment

EDS enrolls dental providers who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a dental provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for dental-related claims.

NOTE:

All nine digits are required when filing a claim.

Dental providers are assigned a provider type of 08 (Dentist). Valid specialties for dental providers include the following:

- General Dentistry (V2)
- Oral and Maxillofacial Surgery (SE)

Oral Surgeons are assigned a provider type of 79 or 01, depending on the source of the licensure information sent to the EDS provider enrollment unit. The valid specialty for Oral Surgeons is Oral and Maxillofacial Surgery (SE).

Oral Surgeons billing medical procedures or CPT procedure codes should refer to Chapter 28, Physician. Only dental procedures (CDT-4 procedure codes) should be billed on the ADA dental claim form.

Enrollment Policy for Dental Providers

To participate in the Alabama Medicaid Program, dental providers must be licensed to practice in the state of Alabama. Each dental provider **must** enroll with EDS, who assigns a provider number for each office location. You must have a different Medicaid provider number for each specific office location. This also applies for reimbursement for preventive services and must be performed at a fixed physical office location. Screenings at other sites are encouraged, but are not billable to Medicaid. Each claim filed constitutes a contract with the Alabama Medicaid Agency. Dental providers are required to complete and sign a coding sheet (often referred to as a "super bill") listing all procedure codes/ descriptions performed on each date of service for each Medicaid recipient. For audit purposes, these coding sheets are required to be maintained on file for a period of three (3) years from the date of service.

Dentists who perform anesthesia or IV sedation services must submit a copy of their GA/IV certification to EDS with their provider enrollment application.

13.2 Informed Consent

Effective July 1, 2003, informed consent shall be documented in the record for all patients for whom comprehensive treatment is to be provided. This informed consent shall include all diagnoses, an explanation of any treatment, therapies, reasonable alternative therapies, their risks, and prognosis.

All informed consents shall be signed by the patient or parent (guardian). If a blanket informed consent is used, a note that such a form was reviewed should be made in the progress notes.

Consistent violation of the informed consent requirement can result in further investigation and appropriate action.

13.3 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Dental care is limited to Medicaid eligible individuals who are under age 21 and are eligible for treatment under the EPSDT Program.

13.3.1 Examinations

Only one of the following four examinations may be billed at a single appointment, when applicable and considering program limitations.

Periodic Oral Examination

A periodic oral examination is an evaluation on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This examination is limited to once every six months for eligible Medicaid recipients.

Limited Oral Examination (Problem Focused)

A limited oral examination is an evaluation or re-evaluation limited to specific health problems. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same day. Typically, recipients receiving this type of evaluation have been referred for a specific problem or are presented with dental emergencies, such as acute infection. Providers using this procedure code must report the tooth number or area of the oral cavity, symptom(s), diagnosis, and emergency treatment in the dental record where the specific problem is suspected. This procedure cannot be billed in conjunction with periodic or comprehensive oral examinations. Limited to one per provider/provider group per year.

Comprehensive Oral Examination

A comprehensive oral examination is used by a general dentist or specialist when evaluating a recipient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This must include the evaluation and recording of: dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (Complete periodontal charting is required if there are signs of periodontal disease or the recipient is ages 16 through 20), hard and soft tissue anomalies, etc. Documentation of the above findings for hard and soft tissues is required even if each finding is normal. This examination is limited to once per recipient, per provider or provider group.

13.3.2 Dental Sealants

Sealant (per tooth) is limited to one per permanent molar only and is non-covered for children less than 5 or greater than 13 years of age. Teeth to be sealed must be free of proximal caries, and there can be no previous restorations on the surface to be sealed. Sealant material must be ADA approved opaque or tinted.

13.3.3 Orthodontic Services

Medicaid provides medically necessary orthodontic services for eligible and qualified recipients. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service at (800) 846-3697or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. All medically necessary orthodontic treatment must be prior authorized by Medicaid before services are provided.

Requests for orthodontic services must include the recommendations of the multidisciplinary team, photos and x-rays.

Criteria for coverage include the following diagnoses when medical necessity exists:

- Cleft palate or cleft lip deformities
- Cleft lip with alveolar process involvement
- Velopharyngeal incompetence
- Short palate
- Submucous cleft
- Alveolar notch
- Craniofacial anomalies included but not limited to
- Hemifacial microsomia
- Craniosynostosis syndromes
- Cleidocranial dysplasia
- Arthrogryposis
- Marfan's syndrome
- Apert's syndrome
- Crouzon’s Syndrome
- Other syndromes by review
- Trauma, diseases, or dysplasias resulting in significant facial growth impact or jaw deformity.

Specific **non-covered services** include the following diagnoses:

- Dento-facial Anomaly, NOS
- Orofacial Anomaly, NOS
- Severe Malocclusion

13.3.4 Radiology

Radiological procedures are limited to those required to make a diagnosis. The radiographs should show all areas where treatment is anticipated.

A full series consisting of at least 14 periapical and bitewing films OR a panoramic film are permitted every three years if professional judgment dictates. Effective July 1, 2003, panoramic films are limited to age 5 and above. A full series (D0210) uses the panoramic film (D0330) *once every three years* benefit and vica versa.

Posterior bitewing and single anterior films may be taken every six months as part of an examination, if medically necessary, subject to the annual limits. All periapical films are limited to a maximum of five per year per recipient. Exceptions: full mouth series or a periapical necessary to treat an emergency (submitted by report).

13.3.5 Non-Covered Services

The following dental services are non-covered except where noted. Non-covered dental services include but are not limited to the following:

- Procedures which are not necessary or do not meet accepted standards of dental practice based on scientific literature
- Surgical periodontal treatment (Exceptions require prior authorization: Pharmaceutically induced hyperplasia and idiopathic juvenile periodontosis)
- Orthodontic treatment (Exception: medically necessary orthodontic services when prior authorized by Medicaid)
- Prosthetic treatment, such as fixed or removable bridgework, or full or partial dentures (Exceptions require prior authorization: prosthesis for closure of a space created by the removal of a lesion or due to congenital defects)
- Panoramic films on recipients under age 5
- Dental transplants
- Dental implants
- Prosthetic implants
- Esthetic veneers
- Silicate restorations
- Pulp caps on primary teeth
- Pulpotomies on permanent teeth
- Space maintainers for premature loss of primary incisors or as “pedo bridges”
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- Extraction of exfoliating primary teeth without a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the record
- Acrylic, plastic restorations (class III or V)
- Acrylic, plastic restorations (class IV)
- Plastic crowns (acrylic)
- Porcelain/ceramic substrate crowns
- Permanent crowns, core buildups, and post & cores on recipients under the age of 15
- Adult Dental Care

Palliative (emergency) treatment cannot be billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures. Only single restorations code can be billed per date of service per tooth.

13.4 Prior Authorization (PA) and Referral Requirements

Prior authorization from Medicaid is required for the following services:

- Periodontal treatment (scaling and root planing, full mouth debridement, periodontal maintenance procedures)
- Excision of hyperplastic tissue
- Hospitalizations for dental care (not required for any out-of state hospitalizations or for children aged 4or under on date(s) of Alabama hospital service)
- Inpatient and outpatient hospitalization and anesthesia charges for adults when hospitalization is required because (1) the individual's underlying medical condition and status is currently exacerbated by the dental condition, or (2) the dental condition is so severe that it has caused a medical condition (for example, acute infection has caused an increased white blood count, sepsis, or bacterial endocarditis in a susceptible patient)
- Space maintainers (after the first two)
- Apicoectomy/periradicular surgery
- Removal of completely bony impactions
- Home visits or treatment of any recipient under age 21 in a licensed medical institution (nursing facility)
- Diagnostic models (when requested by Medicaid)
- Oral/Facial Images (e.g., photographs or slides when requested by Medicaid)
- Therapeutic drug injection (by report)

  Effective July 1, 2004, radiographs greater than 1 year old submitted with Prior Authorization requests will not be acceptable.

  Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

13.4.1 Obtaining Prior Authorization for Dental Services

Providers must use the Prior Review and Authorization Dental Request Form (form 343) to request prior authorization for any of the above procedures. All sections of this form must be completed. The form should be forwarded to EDS, P.O. Box 244032, Montgomery, AL 36124-4032. Refer to Chapter 4, Section 4.4, Obtaining Prior Authorization, of the Alabama Medicaid Provider Manual for instructions on obtaining prior authorization and completion of the form.

Prior authorization requests take approximately two to three weeks for processing. Providers should call the Provider Assistance Center (PAC) at (800) 688-7989 to verify request is in the system if approval/denial is not received within this time frame.

Emergency Prior Authorizations

In an emergency situation where the delay for written request of prior authorization would endanger the health of the recipient, initiate prior authorization by contacting the Alabama Medicaid Agency's Dental Program at (334) 242-5997. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message will be accepted. The voice mail message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- Provider number of dentist
- Phone number of dentist
- Nature of emergency
- Contact person, if other than dentist for follow-up

An Alabama Prior Review and Authorization Dental Request Form (form 343) must be received by the fiscal agent within ten calendar days of the telephone/voice message request. If the request is not received within ten calendar days of the telephone call, the authorization will be denied. The request must meet established guidelines and criteria.

13.4.2 Criteria for Prior Authorization

This section discusses specific criteria for prior authorization for certain periodontal, preventive anesthetic and inpatient/outpatient procedures. There are additional dental procedures that require prior authorization as indicated in Section 13.5.3, Procedure Codes and Modifiers.

- For treatment in the dental office:

  When completing the Alabama Prior Review and Authorization Dental Request (form 343), **ONLY** list those procedures that require prior authorization.

- For treatment in outpatient/inpatient hospital or nursing facility:

  When completing the Alabama Prior Review and Authorization Dental Request (form 343), list **ALL** procedures planned even if they do not normally require prior authorization.

Additional dental prior authorization criteria will be provided to all Medicaid dental providers, as they become available.

Inpatient/Outpatient Hospitalization

Effective January 1, 2005, for prior authorization for patients five years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma

3. Procedure is of sufficient complexity or scope to necessitate hospitalization; The mere extent of caries or large quantity of teeth to be treated, or preference to provide all treatment in one appointment, or need for premedication, are not, by themselves, qualifying reasons for hospitalization.
4. Child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder (requires an additional report described in a. – k. below)

Approval is typically given for a specified time frame not to exceed six months. Treatment must be dentally necessary and supported by a treatment plan and appropriate radiographs. Requests for treatment in a hospital setting based on lack of cooperation, anxiety, attention deficit disorder, or emotional disorder are not typically approved when the dental history shows treatment was rendered in the office in the past.

Documentation from the medical record justifying one or more of the above four criteria is required to be submitted with the Prior Authorization request along with a completed Informed Consent. On children ages 3 and 4, documentation in the record will be required to support the necessity of the treatment performed in a hospital setting.

If Criteria number 4 above (without a physical or mental disability) is cited as the justification for treatment in a hospital setting, it additionally requires a typewritten report of at least one active failed attempt to treat in the office. This report must include:

a. recipient's behavior preoperatively
b. type(s) of behavior management techniques used that are approved by the American Academy of Pediatric Dentistry
c. recipient's behavior during the procedure
d. the use, amount, and type of local anesthetic agent
e. use and dosage of premedication, if attempted
f. use and dosage (%, flow rate and duration) of nitrous oxide analgesia used
g. procedure(s) attempted
h. reason for failed attempt
i. start and end times of the procedure(s) attempted
j. name(s) of dental assistant(s) present in the treatment room
k. presence or absence of parents or guardians in the treatment room

If requirements d, e, or f above were attempted but not successfully accomplished, the report must state the reason(s) for not carrying out or accomplishing these requirements.

Documentation Necessary for Hospital Cases Requiring Dental Prior Authorization (For recipients age 5 or older)

Hospital dental cases may be divided into three categories depending on the documentation obtained in the office. If criteria 4 above is cited as justification for hospital treatment, a typewritten report containing information as described in a. through k. above is also required.

1. **Child is cooperative for x-rays and treatment plan only:** treatment plan (by tooth #, by procedure code) and radiographs were obtained in the office.

Submit Prior Authorization request (form 343) **with informed consent, treatment plan and radiographs** through EDS for review. Failure to attach required information may delay your request.

2. **Child is partially uncooperative:** treatment plan (by tooth #, by procedure code) was obtained but child would not cooperate for radiographs in the office.

Submit Prior Authorization request (form 343) listing the codes on form **with treatment plan and informed consent** along with the explanation that the child would not cooperate for films in Section IV paragraph 3 of form 343. If the Prior Authorization is approved, the approval letter will generally approve **only one procedure code** (usually a radiograph code) and a statement to the effect: "Outpatient/Inpatient Hospital Approved; all other procedures **CONTINGENT UPON**: preoperative radiographs *(type will be specified)* being taken at the hospital and submitted with list of actual treatment procedures directly to Medicaid Agency for review and treatment meeting criteria."

Depending on the extent of the treatment, the preoperative radiographs required in the contingency statement above may vary from bitewings to a panoramic view to a **full mouth series** of radiographs which consists of **14 periapicals and bitewings**. Pay close attention to this contingency statement, as these requirements must be submitted before any review to decide whether requested codes will be added to the Prior Authorization File.

3. **Child is totally uncooperative:** neither the treatment plan nor radiographs could be obtained in the office.

The procedure, approval letter contingencies, and requirements are the same as in # 2 above except that the explanation in Section IV paragraph 3 of Form 343 will include that no films or treatment plan could be obtained in the office.

Outpatient/ASC Admission

Prior authorization is not required for children under 5 years, unless the planned procedure code itself requires a Prior Authorization (e.g. scaling and root planing D4341)

Adult Anesthesia and Facility Fees

Coverage may be available for facility and anesthesia charges through the prior authorization process for medically compromised adults whose dental problems have exacerbated their underlying medical condition. This code covers Anesthesia and Facility fee only and does not cover any dental procedures.

Criteria for coverage of adult anesthesia and facility fees include the following conditions:

- Uncontrolled diabetes
- Hemophilia
- Cardiovascular problems (for example, CHF, prosthetic heart valves, acute endocarditis)
- When an existing qualifying medical condition is presently exacerbated by the dental condition or when the dental condition is so severe that it has caused a medical condition (for example, acute dental infection has caused an increased white blood cell count, sepsis, or bacterial endocarditis in a susceptible patient)

Documentation by the patient's primary care physician must be included with the completed Alabama Prior Review and Authorization Dental request form, which confirms the medical compromise indicated.

13.4.3 Referral Requirements

Dental care is available as a result of EPSDT referral or of the recipient seeking treatment.

EPSDT Referral

If the EPSDT screening provider determines a recipient requires dental care or if the recipient is 3 years of age or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and/or treatment. Medicaid does recommend children be enrolled and under the care of a dentist at one year of age. After the recipient's dental care is initiated, the Consultant's portion of the EPSDT Referral For Services Form must be completed by the dentist and the appropriate copy must be returned to the screening provider.

Recipient Seeking Treatment

If a recipient who has not been screened through the EPSDT Program requests dental care, care may be provided without having an EPSDT Referral Form. Dental care, provided upon recipient's request, is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT provider to obtain a complete medical assessment.

Patient 1st Referrals

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st to determine whether your services require a referral from the Primary Medical Provider (PMP).

Targeted Case Management (TCM)

Alabama's Patient 1st program requires that Medicaid recipients understand the importance of dental care and how to use the dental health care system. Now, professional case managers in the patient's county of residence can complement the dental services of your practice by working with patients you identify as needing additional assistance.

Examples of Targeted Case Management Services:

- Home visits or community follow-up
- Patient education or support
- Tracking and follow-up of children who frequently miss appointments
- Coordinating services for patients with multiple providers and/or complex needs
- Crisis intervention
- Resource assistance

If You Are Concerned About a Patient Because of:

- Non-compliance with dental treatment protocol
- Inappropriate behavior in the dental office
- Need for additional training reinforcement or education
- Missed appointments
- Lack of ability to follow a plan of care
- Language or educational barriers, or
- Risk taking behavior,

then refer this patient to the targeted case manager in the patient's county of residence for further screening, support, counseling, monitoring and education. For a list of managers in your area, call the Dental Program at (334) 242-5997.

13.5 Cost Sharing (Copayment)

Copayment does not apply to services provided by dental providers.

13.6 Completing the Claim Form

Only ADA-approved forms are acceptable. If you experience problems with EDS processing your forms, contact EDS for resolution. Refer to Section 5.4, Completing the ADA Dental Form, for complete instructions on filling out the ADA Dental Form.

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Dental providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

13.6.1 Time Limit for Filing Claims

Medicaid requires all claims for Dental providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

13.6.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

13.6.3 Procedure Codes and Modifiers

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Use the code numbers and procedure descriptions as they appear in this section when filling out the ADA dental form. The listing of a procedure in this section does not imply unlimited coverage. Certain procedures require prior authorization as noted in the PA Required column.

NOTE:

Effective for claims with a Date of Service on or after April 1, 2003, and thereafter, the CDT-4 procedure codes must be used.

Diagnostic Clinical Oral Examinations

Limited oral exam – problem-focused (D0140) must document the tooth number or area of the mouth treated, symptom(s), diagnosis, and emergency treatment in the dental record. This procedure cannot be billed in conjunction with a periodic or comprehensive oral examination.

Procedure Code	***Description of Procedure***	***PA Required***
D0120	Periodic oral examination (limited to once every 6 months)	No
D0140	Limited oral evaluation – problem focused (emergency treatment) Provider must report the tooth number or area of the oral cavity, symptom(s), diagnosis, and emergency treatment in the dental record. Cannot be billed in conjunction with periodic or comprehensive exams. (Limited to one per provider/provider group per year)	No
D0150	Effective January 1, 2004 this must include the evaluation and recording of: dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting if there are signs of periodontal disease OR age 16 and older), hard and soft tissue anomalies, etc. Documentation of the above findings for hard and soft tissues is required even if each finding is normal. (Once per recipient's lifetime per provider or provider group)	No

Radiographs

All films must be of diagnostic quality suitable for interpretation, mounted in proper x-ray mounts marked Right and Left, and identified by type, date taken, recipient's name, and name of dentist. When billing Intraoral - Periapical, first film, and Periapical, each additional film (D0230) a tooth number/letter is required in tooth number column on electronic or paper claim. Any combination of periapical films with or without bitewings taken on the same date of service which exceed the maximum allowed, must be billed as a Complete Intraoral Series (D0210). Billing of individual film codes in this instance would be suspect fraud. Periapical films must have a valid indication documented in the record (e.g. aid in diagnosing an emergency, endodontic obturation evaluation, etc.) Routine use of periapical radiographs(s) at periodic/comprehensive evaluations evaluations or treatment appointments without valid documented indications are not allowable. Effective July 1, 2004, radiographs submitted greater than 1 year old are not acceptable.

Procedure Code	*Description of Procedure*	*PA Required*
D0210	Intraoral – Complete series, including bitewings, consists of 14 periapicals and bitewings (Limit once every 3 years) A complete series uses the benefit of a panoramic film. Any combination of D0220, D0230, D0272, or D0274 taken on the same date of service, which exceeds the maximum allowed fee for D0210 must be billed as D0210	No
D0220	Intraoral – Periapical, first film (Limit 1 per year effective April 1, 2003) Not allowed on the same date of service as D0210	No
D0230	Intraoral – Periapical, each additional film (Limit 4 per year effective April 1, 2003) Not allowed on the same date of service as D0210	No
D0240	Intraoral – Occlusal film (requires code 01 or 02 in tooth # field on claim indicating maxillary or mandibular arches)	No
D0250	Extraoral – first film	No
D0260	Extraoral – each additional film	No
D0272	Bitewings – two films (Limit 1 every six months) Not allowed on same the date of service as D0274	No
D0274	Bitewings - four films (Limit 1 every six months, effective July 1, 2003 procedure restricted to age 13 or older) Not allowed on same the date of service as D0272	No
D0330	Panoramic film (Cannot be billed in addition to D0210, and limited to once per recipient every three years, effective July 1, 2003 procedure restricted to age 5 or older) A panoramic film uses the benefit of a complete series (D0210)	No
D0350	Oral/facial images (traditional photos and intraoral camera images) *Oral/facial images are authorized only when required by Medicaid*	Yes

Tests and Laboratory Examinations

Procedure Code	*Description of Procedure*	*PA Required*
D0470	Diagnostic casts, per model. Models must be trimmed and able to be articulated and must include bases. *Diagnostic casts are authorized only when required by Medicaid.*	Yes

Preventive Services

Dental prophylaxis includes scaling and/or polishing. When billing for prophylaxis and fluoride treatment provided on the same date of service

for a recipient, use of only the combined code is appropriate (D1201 or D1205).

Procedure Code	***Description of Procedure***	***PA Required***
D1110	Prophylaxis - Adult (over 12 years of age) (limited once every 6 months) Not allowed on the same date of service as: D1204, D1205, D4341, D4355, or D4910	No
D1120	Prophylaxis - Child (up to and including 12 years of age) (limited once every 6 months) Not allowed on the same date of service as: D1201, D1203, D4341, D4355, or D4910	No
D1201	Topical fluoride with prophylaxis – Child (up to and including 12 years of age) **Trays, Not Paste** (limited once every 6 months) Not allowed on the same date of service as: D1110, D1203, D4341, D4355, or D4910	No
D1203	Topical application of fluoride (excluding prophylaxis) – Child (up to and including 12 years of age) (limited once every 6 months) Not allowed on the same date of service as: D1120 or D1201	No
D1204	Topical application of fluoride (excluding prophylaxis) – Adult (over 12 years of age) (limited once every 6 months) Not allowed on the same date of service as: D1110 or D1205	No
D1205	Topical fluoride with prophylaxis – Adult (over 12 years of age) **Trays, Not Paste** (limited once every 6 months) Not allowed on the same date of service as: D1110, D1204, D4341, D4355, or D4910	No
D1351	Sealant, per tooth only covered for teeth: 02,03,14,15,18,19,30,31, on children aged 5 through 13 years) Limit one per tooth per lifetime	No

Space Maintainers

Effective July 1, 2003, space maintainers are covered on the following missing teeth ONLY:

1. Premature loss of second primary molar (A,J,K,T)
2. Premature loss of first primary molar (B,I,L,S) except in mixed dentition with normal class I occlusion
3. Premature loss of primary canines (C,H,M,R)

Space maintainers are NON-COVERED in the following instances:

- For premature loss of primary incisor teeth or as "pedo bridges"
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- More than once per recipient's lifetime for a given space(tooth) to be maintained
- Space maintainers for the loss of permanent teeth

Space maintainers, when indicated, should be placed as soon as possible after early primary tooth loss, but no later than 180 days after extraction or loss. The claim or prior authorization form must show the primary tooth letter that has been prematurely lost. If more than one deciduous tooth is lost, show the letter of the most recent tooth lost, which will be replaced by the space maintainer. The first two space maintainer procedure codes billed regardless of tooth do not require prior authorization, but must meet coverage requirements. Prior authorization with justification is required for the billing of each additional space maintainer procedure code after the first two.

Procedure Code	***Description of Procedure***	***PA Required***
D1510	Space maintainer- fixed, unilateral	Yes (See above)
D1515	Space maintainer- fixed, bilateral	Yes (See above)
D1520	Space maintainer – removable, unilateral	Yes (See above)
D1525	Space maintainer- removable, bilateral	Yes (See above)
D1550	Re-cement space maintainer	Yes (See above)

Restorative Services

Fee for restorative service includes: all adhesives including amalgam or resin bonding agents, lining or base, restoration, and local anesthesia or analgesia, if necessary. Amalgam or resin restorations are not covered on a tooth receiving any of the following procedures: stainless steel crowns (D2930, D2931), resin crowns (D2932), core buildups (D2950), post & cores (D2952, D2953, D2954, D2957), or crowns (D2750, D2751, D2752, or D2792). Amalgam or resin codes (D2140 – D2394) may not be billed in substitution for a core buildup (D2950). Primary tooth restorations are not allowed when normal exfoliation is imminent. Multiple restorations with at least one surface touching each other will be considered one restoration. All cervical restorations will be considered as a single surface restoration. Effective July 1, 2005 restorations (D2140 – D2394) on primary teeth are not covered unless there is greater than one-third of the original root length remaining.

Amalgam Restorations (Including Polishing)

Procedure Code	***Description of Procedure***	***PA Required***
D2140	Amalgam – one surface, primary or permanent	No
D2150	Amalgam – two surfaces, primary or permanent	No
D2160	Amalgam – three surfaces, primary or permanent	No
D2161	Amalgam – four or more surfaces, primary or permanent	No

Composite Restorations

Resins are not allowed for preventive procedures or cosmetic purposes (e.g. diastema closure, discolored teeth, correction of developmental anomaly, etc.). Composite restorations are now authorized for all surfaces including occlusal surfaces. Preventive resins (resins placed on any surface without documented caries into dentin) are not covered.

Procedure Code	*Description of Procedure*	*PA Required*
D2330	Resin – one surface, anterior	No
D2331	Resin – two surfaces, anterior	No
D2332	Resin – three surfaces, anterior	No
D2335	Resin – four or more surfaces or involving incisal (anterior) angle	No
D2391	Resin - one surface, posterior	No
D2392	Resin - two surfaces, posterior	No
D2393	Resin - three surfaces, posterior	No
D2394	Resin - four or more surfaces, posterior	No

Crowns, Single Restorations Only

Medicaid covers crowns, post & cores, and core buildups **only** following root canal therapy (D3310, D3320, D3330) which must qualify for Medicaid coverage. Effective July 1, 2003, crowns (excluding stainless steel or resin crowns), core buildups and post & cores are limited to the permanent teeth on eligible recipients age 15 years or older following root canal therapy. Limited to one per tooth per lifetime. Crowns, post & cores, and buildups on 3rd molars are not covered.

Amalgam or resin restorations or sedative fillings are not authorized on teeth being crowned with or without a core buildup or post and core.

*No prior authorization is required for crowns, core buildups, or post & cores, if a completed root canal treatment is in Medicaid's history. If no root canal is in Medicaid's history, send a diagnostic postoperative periapical x-ray (bitewings or panoramic films are not acceptable) of completed root canal taken AFTER the crown has been inserted with completed claim form directly to: AL Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36130-5624.

Effective January 1, 2005 reimbursement fees for crown (D2750 – D2792) procedures include any: crown follow up appointments, equilibration, or recementation within 6 months of insertion.

Procedure Code	*Description of Procedure*	*PA Required*
D2750	Crown – porcelain fused to high noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2751	Crown – porcelain fused to predominantly base metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2752	Crown – porcelain fused to noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2792	Crown – full cast metal (limited to age 15 or older, on endodontically treated teeth only)	No*

Incomplete Procedures

Effective July 1, 2003 for multiple appointment procedures, payment will be made to the provider that started the procedure. Documentation that several attempts were made to complete the procedure (i.e. phone calls, letters) must be supported in the medical record. Billing should only occur after documentation of failed attempts to complete. If the recipient is treated by a subsequent provider for the same procedure, same tooth, the services are considered non-covered.

Other Restorative Services

Procedure Code	***Description of Procedure***	***PA Required***
D2920	Re-cement crown - Limit 2 per lifetime per tooth and none allowed within the first six months of placement	No
D2930	Prefabricated stainless steel crown, primary tooth The following are indications for placement of stainless steel crowns (prefabricated crown forms) for fitting on individual teeth: • For the restoration of primary and permanent teeth with caries, cervical decalcification, and/or development defects (hypoplasia and hypocalcification) • When the failure of other restorative materials is likely with interproximal caries extended beyond line angles • Following pulpotomy or pulpectomy • For restoring a primary tooth being used as an abutment for a space maintainer, or • For restoring fractured teeth when the tooth cannot be restored with other restorative materials. Effective July 1, 2003 amalgam or resin restorations, sedative (temporary) fillings, core buildups, pin retention, or post and cores are not authorized on primary or permanent teeth receiving a stainless steel crown.	No
D2931	Prefabricated stainless steel crown, permanent tooth. See indications and limitations listed under D2930 above.	No
D2932	Prefabricated resin crown Amalgam or resin restorations, sedative (temporary) fillings, core buildups, pin retention, or post and cores are not authorized on primary or permanent teeth receiving a prefabricated resin crown. Allowable on anterior teeth only.	No
D2940	Sedative fillings - temporary restoration intended to relieve pain. not to be used as liners or bases under restorations~~)~~. Not allowable with: amalgam or resin restoration, endodontically treated teeth, core buildups, posts and cores, done on same tooth, same DOS. Limit one per tooth.	No
D2950	Core buildup, including any pins. Not covered on primary teeth. (limited to age 15 or older)	No**

Procedure Code	*Description of Procedure*	*PA Required*
	Not allowable on the same tooth with: • Amalgam or resins (D2140 – D2394) • Posts & Cores (D2952, D2953, D2954, D2957) Sedative (temporary) fillings (D2940) Pins (D2951)	
D2951	Pin retention – per tooth in addition to restoration (limited to age 15 or older) Not allowable with D2950	No
D2952	Cast post and core in addition to crown - Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No**
D2953	Each additional cast post – same tooth - (maximum of 2) Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No**
D2954	Prefabricated post and core in addition to crown - (maximum of 1) Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No**
D2957	Each additional prefabricated post – same tooth – (maximum of 1) Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No**

Effective July 1, 2003, the following codes require a diagnostic pre-treatment and post-treatment periapical radiograph be taken and maintained on file: D2750, D2751, D2752, D2792, D2952, D2953, D2954, and D2957. Effective July 1, 2004, to qualify for coverage: posts must be radiographically visible and distinct from the obturation material. "So-called Posts" made in the office solely by flowing or compacting materials into the canal(s), such as resins, polymers, acrylics, amalgams, etc., are not covered. In order to qualify for coverage, posts must be fitted and cemented within the prepared root canal, and be attached to the core in order to retain the core. Posts which do not meet criteria for coverage will not be covered as core buildups. Core buildups and posts & cores are only covered on teeth which are receiving crowns and are limited to once per eligible tooth per lifetime.

Effective July 1, 2003, the following codes require a diagnostic pre-treatment and post-treatment periapical radiograph be taken and maintained on file: D2750, D2751, D2752, D2792, D2952, D2953, D2954, and D2957. Effective July 1, 2004, to qualify for coverage: posts must be radiographically visible and distinct from the obturation material. Posts made in the office solely by flowing or compacting materials into the

canal(s), such as resins, polymers, acrylics, amalgams, etc., are not covered.

Endodontics

Pulp Capping

Bases and sedative fillings do not qualify as pulp caps. Pulp caps without a protective restoration are not covered.

Procedure Code	***Description of Procedure***	***PA Required***
D3110	Pulp cap, Direct (excluding final restoration) Covered for permanent teeth only. Pulp cap must cover a documented exposed pulp. (limit one per tooth)	No
D3120	Pulp cap, Indirect (excluding final restoration) Covered for permanent teeth only. Effective January 1, 2005, indirect pulp caps are only covered for documented treatment of **deep** carious lesions near the dental pulp with a protective dressing over the remaining carious dentin to prevent operative pulp exposure. (limit one per tooth)	No

Pulpotomy/Pulpectomy

Only the single most appropriate endodontic code should be billed. It is not appropriate to bill pulpotomy/pulpectomy (D3220) and pulpal therapy on primary teeth (D3230 or D3240) for the same tooth. D3220 must not be billed with D3310, D3320, D3330 or D3332 for the same tooth, as these four codes already include a pulpotomy or pulpectomy. Pulpotomies are not covered for permanent teeth effective July 1, 2003.

Procedure Code	***Description of Procedure***	***PA Required***
D3220	Therapeutic pulpotomy (Covered for primary teeth only, excluding final restoration)	No

Primary Endodontics

Procedure Code	***Description of Procedure***	***PA Required***
D3230	Pulpal therapy, anterior primary tooth	No
D3240	Pulpal therapy, posterior primary tooth	No

D3230 and D3240 would be covered ONLY when all of the following documented indications exist: the primary tooth is restorable and must be saved until the permanent tooth erupts, the pulp is non-vital with no radiographic signs of internal or external root resorption, and a succedaneous tooth is present. These procedures require a complete pulpectomy, diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file. These radiographs must show successful filling of canals with a resorbable filling material without gross overextension or underfilling. Follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Endodontics on Permanent Teeth

Root canal therapy applies to permanent teeth only. Therapy includes treatment plan, clinical procedures, radiographs, temporary fillings, and follow-up care. Endodontics on third molars is not a covered procedure. The following codes are covered only on permanent teeth and require a diagnostic pre-treatment and post-treatment periapical radiograph be taken and maintained on file: D3310, D3320, D3330, D3351, D3410, and D3430. Endodontics (D3310 – D3430) is **only** covered when there are documented tests performed (electrical pulp tests, thermal, percussion, palpation) in the record consistent with radiographic findings and symptoms which support a documented pulpal pathology diagnosis of an irreversible nature on a specific restorable tooth and one of the following procedures are indicated: D3310, D3320, or D3330. Intentional endodontics performed for reasons other than documented irreversible pulpal pathology of a specific restorable tooth, such as, but not limited to: prosthetics, bleaching, orthodontics, non-covered periodontal or oral surgery procedures, pain of undetermined origin, preference of the recipient or provider, etc. are not covered.

Procedure Code	***Description of Procedure***	***PA Required***
D3310	Anterior, excluding final restoration (age 6 or older)	No
D3320	Bicuspid, excluding final restoration (age 9 or older)	No
D3330	Molar, excluding final restoration (age 6 or older)	No
D3332	Incomplete endodontic therapy; inoperable or fractured tooth (age 6 or older)	No
D3351	Apexification, per treatment visit (nonvital permanent teeth only) This procedure is only covered after apical closure is obtained and demonstrated with a postoperative periapical radiograph maintained in the record. This postoperative film must be taken after apexification is completed but before canal obturation is performed. Usually several treatments are required. Treatment performed in less than 180 days is not covered.	No

Periapical Services

Procedure Code	***Description of Procedure***	***PA Required***
D3410	Apicoectomy - Anterior, per tooth - Limit 1 per tooth per lifetime	Yes
D3430	Retrograde filling - Limit 1 per tooth per lifetime (covered only in conjunction with D3410 on anterior teeth)	Yes

D3310, D3320, D3330, D3410 and D3430: require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file. In addition, follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Prior Authorization requests for D3410 and D3430 require a postoperative endodontic periapical film with the history and examination findings to include: symptoms, periodontal probings, palpation, percussion, mobility,

presence of swelling or sinus tract, etc. and an explanation of why re-treatment is not being considered.

Periodontics

Periodontics requires prior authorization. Prior authorization for periodontal therapy codes, D4341 or D4910 requires the following:

- Complete periodontal charting (including probing depths) and free gingival margins in relation to Cementoenamel Junctions(CEJs)
- Posterior bitewing radiographs and any involved anterior periapical or bitewing radiographs to be submitted with the prior authorization request

Procedure Code	***Description of Procedure***	***PA Required***
D4341	Periodontal scaling and root planing, per quadrant Prior authorization for scaling and root planing requires documentation of pocket depths as follows: • Patients over 12 years old must have a generalized pocket depth greater than 4 mm, with demonstrable radiographic evidence of generalized periodontitis. (This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque from these surfaces.) • For patients under 12 years old, this procedure is ordinarily not indicated unless some unusual circumstance requires a more in-depth review and documentation (for example, familial juvenile periodontitis.) • This procedure will not be authorized for treatment of pseudopockets. • This procedure requires that radiographs (posterior bitewings and anterior periapicals or bitewings) and complete periodontal charting (including probing depths, free gingival margins in relation to CEJs, etc.) be provided with the request. A limit of no more than **two quadrants** of scaling and root planing will be permitted for each date of service, except for patients treated as inpatient/outpatient hospitalization cases. This procedure not allowed for same quadrant, same date of service with: D1110, D1120, D1201, D1205, D4355, or D4910.	Yes

Procedure Code	*Description of Procedure*	*PA Required*
D4355	Full mouth debridement Covered only when subgingival and/or supragingival plaque and calculus obstruct the ability to perform a comprehensive oral evaluation. This is a preliminary procedure and does not rule out the need for other procedures. This procedure requires that appropriate radiographs (bitewings, periapicals) be sent with the request. Clinical photographs/images may be required upon request. This procedure is not allowed on the same date of service or within 21 days of scaling and root planing. If prior approved, this procedure must be performed before a comprehensive evaluation is done. This procedure is not allowed on same date of service or within 6 months of : D1110, D1120, D1201, D1205, D4341, or D4910	Yes
D4910	Periodontal maintenance procedures Prior authorization for Periodontal/Special Maintenance following active therapy requires the following information: • A clinical description of the service • Procedure recommendations • X-rays • Complete periodontal charting (probing depths, free gingival margins in relation to CEJs) • CDT-4 procedure code • The number of units or visits Approval is typically given for a specified time frame of one to three months. This procedure is not allowed on same date of service with: D1110, D1120, D1201, D1205, D4341 or D4355	Yes

Oral Surgery

Extractions

Extractions include local anesthesia, aveoloplasty, and routine postoperative care. Extractions of exfoliating primary teeth will not be covered unless there is a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the dental record.

Procedure Code	*Description of Procedure*	*PA Required*
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No

Surgical Extractions

Effective July 1, 2003, surgical extractions include and require documentation of local anesthesia, alveoloplasty, mucoperiosteal flap elevation, osseous removal, sectioning and removal of tooth structure, sutures, and routine postoperative care. Radiographs are required with PA request for procedure codes D7240 and D7241. D7241 requires a report by tooth number of actual unusual surgical complication(s). The following codes are only covered for permanent teeth: D7210, D7220, D7230, D7240, D7241, and D7250. Exception: Ankylosed or impacted primary teeth may be submitted by report with radiographs. Extractions due to crowding to facilitate orthodontics are not covered unless the orthodontics is covered meeting Medicaid criteria.

Procedure Code	***Description of Procedure***	***PA Required***
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Requires documentation of cutting of both gingival and bone, removal of tooth structure, and closure. (covered for permanent teeth only)	No
D7220	Removal of impacted tooth – soft tissue occlusal surface must be covered by soft tissue, requires documentation of mucoperiosteal flap elevation, (covered for permanent teeth only)	No
D7230	Removal of impacted tooth – partially bony a portion of the crown must be covered by bone, requires documentation of mucoperiosteal flap elevation and bone removal (covered for permanent teeth only)	No
D7240	Removal of impacted tooth – completely bony most or all of the crown must be covered by bone, requires documentation of mucoperiosteal flap and bone removal, (covered for permanent teeth only)	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications most or all of the crown must be covered by bone, requires documentation of mucoperiosteal flap and bone removal, (covered for **actual** complications only by report, covered for permanent teeth only)	Yes
D7250	Surgical removal of residual tooth roots must require documentation of cutting of both soft tissue and bone and removal of tooth structure. Not covered if a portion or all of crown is present (covered for permanent teeth only)	No

Procedures: D7210, D7220, D7230, D7240, D7250 requirements listed above (i.e. flap, bone removal, sectioning, etc.) must be documented in the dental record to be covered.

Other Surgical Procedures Applied To Teeth

Procedure Code	*Description of Procedure*	*PA Required*
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus This fee includes any composite or bonding attachment to evulsed or displaced tooth and adjacent teeth as well as any brackets, wire or line used.	No
D7280	Surgical exposure of impacted or unerupted tooth to aid eruption	No
D7285	Biopsy of oral tissue, hard (bone, tooth)	No
D7286	Biopsy of oral tissue, soft (all others)	No

Removal of Tumors, Cysts, and Neoplasms

Procedure Code	*Description of Procedure*	*PA Required*
D7410	Excision of benign lesion up to 1.25 cm	No
D7450	Removal of odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7451	Removal of odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No
D7460	Removal of non-odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7461	Removal of non-odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No

Excision of Bone Tissue

Procedure Code	*Description of Procedure*	*PA Required*
D7471	Removal of exostosis – per site	No
D7510	Incision and drainage of abscess, intraoral soft tissue Requires documentation of incision through mucosa, area of incision, presence of any purulence from the abscess, use of any drain or sutures. Not allowed in same site as a surgical tooth extraction. Incisions through the gingival sulcus are not covered.	No
D7520	Incision and drainage of abscess, extraoral soft tissue Requires documentation of incision through skin and area of incision, type of drain (if any) and sutures (if closed)	No

Treatment of Fractures - Simple

Procedure Code	*Description of Procedure*	*PA Required*
D7610	Maxilla - open reduction (teeth immobilized if present)	No
D7620	Maxilla - closed reduction (teeth immobilized if present)	No
D7630	Mandible - open reduction (teeth immobilized if present)	No
D7640	Mandible - closed reduction (teeth immobilized if present)	No

Reduction of Dislocation - Management of Other Temporomandibular Joint Dysfunctions

Procedure Code	*Description of Procedure*	*PA Required*
D7820	Closed reduction of dislocation	No

Other Repair Procedures

Excision of hyperplastic tissue (D7970) requires:

- Complete periodontal charting (including probing depths and free gingival margins in relation to CEJs)
- Medical documentation, that the hyperplasia is drug-induced
- Possible oral images/photographs (if required by Medicaid)

Procedure Code	*Description of Procedure*	*PA Required*
D7911	Complicated suture, up to 5 cm.	No
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	No
D7970	Excision of hyperplastic tissue; per arch (covered for drug-induced cases only)	Yes
D7971	Excision of pericoronal gingiva (covered for partially erupted or impacted teeth only) Use for operculectomy Not allowed for crown lengthening or gingivectomy	No

Orthodontics

Orthodontic services require prior authorization. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. See Section 13.3.3 of this chapter entitled *Orthodontic Services* for more details.

Adjunctive General Services

Procedure Code	*Description of Procedure*	*PA Required*
D9110	Palliative (emergency) treatment of minor dental pain. This procedure requires documentation in the record of: symptoms, findings, tests (if performed), radiographs if taken, diagnosis, and description of emergency treatment. Cannot be billed with the following definitive or emergency procedures: D0210, D0350, D0470, D1110 through D7970, D7971, D9220 and D9610. This is a specific code and must not be used to bill for any procedure that has its own unique code, even if the most appropriate code is not covered. Always bill the most appropriate CDT-4 code. (Limit one per visit)	No

Procedures

The following procedures are limited to one per visit when not covered by separately listed procedures.

Anesthesia

Procedure Code	*Description of Procedure*	*PA Required*
D9220	General anesthesia (requires current state board GA permit)	No
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide or similar analgesia is authorized for payment in special cases such as mentally retarded or extremely uncooperative patients. Effective April 1, 2004, documentation of medical necessity, written informed consent, and nitrous oxide dosage (% nitrous oxide and/or flow rate, duration), must be in the medical record. The provider or recipient's desire to use this procedure, by itself, does not qualify it as medically necessary.	No
D9241	Intravenous sedation/analgesia (requires current state board IV or GA permit)	No

Drugs

Procedure Code	*Description of Procedure*	*PA Required*
D9610	Therapeutic drug injection, by report billable only when no definitive treatment rendered in same visit	Yes

Tooth Numbers and Letters

- Enter the tooth number or letter for the appropriate tooth. Use the letters and/or numbers shown on the dental chart. Additional tooth designations are listed below. Insert these in the “Tooth # or Letter” block on the claim when indicated.
- Tooth Numbers should include for Permanent dentition: 01 through 32
- Tooth Numbers should include for Primary dentition: A through T
- Supernumerary are as follows:

A supernumerary tooth for Permanent Dentition (Tooth numbers 01-32) would have 50 added to its tooth number. Therefore if a patient had an extra tooth number 30 it would be coded as tooth number '80' (30 + 50 = 80). Valid numbers would be 51 through 82. Primary dentition (Tooth numbers “A” through “T”) would place an 'S' after the tooth code. If a patient had an extra 'A' tooth, it would be coded 'AS'. Valid letters would be ‘AS’ through ‘TS’.

The following codes may be used in conjunction with those listed on the claim form:

Code	***Designation***	***Code***	***Designation***
00	Full mouth	30	Lower Left Quadrant
01	Upper Arch	40	Lower Right Quadrant
02	Lower Arch		
10	Upper Right Quadrant	L	Left
20	Upper Left Quadrant	R	Right

Surface

Please bill the single most appropriate surface involved using the following abbreviations:

Code	***Designation***	***Code***	***Designation***
B	Buccal; Labial	L	Lingual
D	Distal	M	Mesial
I	Incisal	O	Occlusal
F	Facial; Labial		

When more than one surface on the same tooth is affected, use the following combinations:

2 Surfaces			***3 Surfaces***				***4 Surfaces***		***5 Surfaces***	
MO	IF	ML	MOD	IFL	BOL	MID	MODB	MIFL	*MODBL*	*MODFL*
DB	IL	OB	MOB	MIL	DOB	MIF	MODL	DIFL	*MIDBL*	*MIDFL*
MB	DI	DO	MOL	DIL	DOL	DIF	MOBL	MIDL		
DL	MI	OL	MBD	MLD			MIDF			

13.6.4 Place of Service Codes

The following place of service codes apply when filing claims for dental services:

Place of Service Codes	*Place of Service*
11	Dental office
21	Inpatient hospital
22	Outpatient hospital
31	Skilled nursing facility or nursing facility

NOTE:

Place of service codes other than 11 require prior authorization before delivery of the service, unless recipient is under 6 years old.

13.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

13.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
ADA Dental Claim Form Instructions	Section 5.4
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Dental Prior Authorization Form	Section 4.4

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